FOR OHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. **IDPH Facility ID Number:** 0046094

Facility Name: Sunset Rehabilitation & Health Care

Address: 129 South 1st Avenue (Number) Canton (City) 61520 (Zip Code)

County: Fulton

Telephone Number: (309) 674-4327 **Fax #** (309) 674-4354

IDPA ID Number: 370997695001

Date of Initial License for Current Owners: 08/01/1990

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact
Name: Christine A. Hanover **Telephone Number:** (312) 634-4581
Please send copies of desk review and audit adjustments to address on this page

II. **CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 9/1/2005

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	17	Skilled (SNF)	25	7,181	1
2		Skilled Pediatric (SNF/PED)			2
3	90	Intermediate (ICF)	90	32,850	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	107	TOTALS	115	40,031	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,057		2,608	6,665	8
9	SNF/PED					9
10	ICF	23,064	7,429		30,493	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,121	7,429	2,608	37,158	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.82%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location
Date started 08/01/90

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/01/90 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 2,608

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basi

SEE ACCOUNTANTS' COMPILATION REPORT

Sunset Rehabilitation & Health Care
Provider #: 0046094
01/01/2005 to 12/31/2005 **Schedule 2A**

Line 7 - Licensed Bed Days

	Beds	Days	Total	
1/1/05 - 8/31/05	107	243	26,001	
9/1/05 - 12/31/05	115	122	14,030	
		365	40,031	Beds available

SEE ACCOUNTANTS' COMPILATION REP

PORT

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger: Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	150,464	27,799		178,263		178,263	4,469	182,732			1
2	Food Purchase		165,144		165,144		165,144	(30,252)	134,892			2
3	Housekeeping	162,724	15,163		177,887		177,887	101	177,988			3
4	Laundry	50,382	12,433		62,815		62,815	8	62,823			4
5	Heat and Other Utilities			89,666	89,666		89,666	681	90,347			5
6	Maintenance	22,920	46,893	12,974	82,787		82,787	5,862	88,649			6
7	Other (specify):* Mgmt. Co. Benefits							1,276	1,276			7
8	**TOTAL General Services**	386,490	267,432	102,640	756,562		756,562	(17,855)	738,707			8
	B. Health Care and Programs											
9	Medical Director			7,800	7,800		7,800		7,800			9
10	Nursing and Medical Records	1,453,822	77,916	2,303	1,534,041		1,534,041	7,392	1,541,433			10
10a	Therapy	55,098	130	40,518	95,746		95,746	5	95,751			10a
11	Activities	34,078	1,024		35,102		35,102		35,102			11
12	Social Services	24,410	954		25,364		25,364		25,364			12
13	CNA Training											13
14	Program Transportation	17,231			17,231		17,231		17,231			14
15	Other (specify):* Mgmt. Co. Benefits							1,024	1,024			15
16	**TOTAL Health Care and Programs**	1,584,639	80,024	50,621	1,715,284		1,715,284	8,421	1,723,705			16
	C. General Administration											
17	Administrative	52,159			52,159		52,159	31,655	83,814			17
18	Directors Fees											18
19	Professional Services			8,914	8,914		8,914	9,191	18,105			19
20	Dues, Fees, Subscriptions & Promotion			2,064	2,064		2,064	4,184	6,248			20
21	Clerical & General Office Expense	10,870	9,507	12,926	33,303		33,303	38,837	72,140			21
22	Employee Benefits & Payroll Taxe			354,995	354,995		354,995	3,263	358,258			22
23	Inservice Training & Educatior			2,786	2,786		2,786	664	3,450			23
24	Travel and Seminar			704	704		704	910	1,614			24
25	Other Admin. Staff Transportatior			17,642	17,642		17,642	3,257	20,899			25
26	Insurance-Prop.Liab.Malpractice			48,711	48,711		48,711	1,208	49,919			26
27	Other (specify):* Mgmt. Co. Benefits							9,087	9,087			27
28	**TOTAL General Administration**	63,029	9,507	448,742	521,278		521,278	102,256	623,534			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,034,158	356,963	602,003	2,993,124		2,993,124	92,822	3,085,946			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.** SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sunset Rehabilitation & Health Care #0046094 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			126,681	126,681		126,681	59,493	186,174			30
31	Amortization of Pre-Op. & Org											31
32	Interest			204,633	204,633		204,633	7,788	212,421			32
33	Real Estate Taxes			36,000	36,000		36,000		36,000			33
34	Rent-Facility & Grounds							734	734			34
35	Rent-Equipment & Vehicles			9,848	9,848		9,848	180	10,028			35
36	Other (specify):*											36
37	TOTAL Ownership			377,162	377,162		377,162	68,195	445,357			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		8,545		8,545		8,545		8,545			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,583	58,583		58,583		58,583			42
43	Other (specify):* Nonallowable Cost	10,937		56,539	67,476		67,476	(67,476)				43
44	TOTAL Special Cost Centers	10,937	8,545	115,122	134,604		134,604	(67,476)	67,128			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,045,095	365,508	1,094,287	3,504,890		3,504,890	93,541	3,598,431			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See Schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals	(27,131)	2		4
5	Telephone, TV & Radio in Resident Room	(6,026)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	53,675	30		9
10	Interest and Other Investment Income	(41)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,120)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,750)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,988)	43		24
25	Fund Raising, Advertising and Promotional	(20,405)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG 5A	(26,249)	var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (43,035)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	136,576		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 136,576		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 93,541		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Programs		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Sunset Rehabilitation & Health Care

ID# 0046094

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. - Part A	$ (688)	43	1
2	Labs - Part A	(8,085)	43	2
3	X-Rays - Part A	(2,864)	43	3
4	Marketing salary	(10,937)	43	4
5	Special events	(1,613)	43	5
6	Offset transportation income	(54)	25	6
7	Offset miscellaneous income	(2,008)	21	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(26,249)		49

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See attached Schedule 6A		See attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 4,469	$ 4,469	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	142	142	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	101	101	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	8	8	4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	681	681	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	5,862	5,862	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,276	1,276	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	7,392	7,392	8
9	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	5	5	9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,024	1,024	10
11	V	17	Administrative		Petersen Health Care, Inc.	100.00%	31,655	31,655	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	9,191	9,191	12
13	V	20	Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	4,184	4,184	13
14	Total			$			$ 65,990	$ * 65,990	14

* Total must agree with the amount recorded on line 34 of Schedule VI

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Clerical & General Office	$	Petersen Health Care, Inc.	100.00%	$ 40,845	$ 40,845	15
16	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	664	664	16
17	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	910	910	17
18	V	25	Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	3,311	3,311	18
19	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	1,208	1,208	19
20	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	9,087	9,087	20
21	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	5,818	5,818	21
22	V	32	Interest		Petersen Health Care, Inc.	100.00%	7,829	7,829	22
23	V	34	Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	734	734	23
24	V	35	Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	180	180	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 136,576	$ * 136,576	39

*** Total must agree with the amount recorded on line 34 of Schedule VI**

SEE ACCOUNTANTS' COMPILATION REPORT

Sunset Manor Nursing Home
Provider # 0046094
12/31/2005

Schedule 6A

VII Related Parties - Page 6

Related Nursing Homes	City
In-State:	
Aledo Rehabilitation & Health Care Center	Aledo, IL
Arcola Health Care Center	Arcola, IL
Arrow Wood Estates of Rock Falls	Rock Falls, IL
Aspen Rehab & Health Care	Silivis, IL
Batavia Rehabilitation & Health Care Center	Batavia, IL
Bement Health Care Center	Bement, IL
Benton Rehabilitation & Health Care Center	Benton, IL
Bloomington Rehabilitation & Health Care Center	Bloomington, IL
Casey Health Care Center	Casey, IL
Cisne Rehabilitation & Health Care Center	Cisne, IL
Countryview Care Center of Macomb	Macomb, IL
Countryview Terrace	Louisville, IL
Decatur Rehabilitation & Health Care Center	Decatur, IL
Eastside Health & Rehabilitation Center	Pittsfield, IL
Eastview Terrace	Sullivan, IL
Effingham Rehabilitation & Health Care Center	Effingham, IL
El Paso Health Care Center	El Paso, IL
Elgin Rehabilitation & Health Care Center	South Elgin, IL
Enfield Rehabilitation & Health Care Center	Enfield, IL
Flora Health Care Center	Flora, IL
Fondulac Rehabilitation & Health Care Center	East Peoria, IL
Havana Health Care Center	Havana, IL
Ironwood Estates of Sandwich	Sandwich, IL
Jonesboro Rehabilitation & Health Care Center	Jonesboro, IL
Kewanee Care Home	Kewanee, IL
McLeansboro Rehabilitation & Health Care Center	McLeansboro, IL
Newman Rehabilitation & Health Care Center	Newman, IL
North Aurora Care Center	Aurora, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie Rose Health Care Center	Pana, IL
Robings Manor Nursing Home	Brighton, IL
Rock Falls Rehabilitation & Health Care Center	Rock Falls, IL
Rosiclare Rehabilitation & Health Care Center	Rosiclare, IL
Royal Oaks Care Center	Kewanee, IL
Sandwich Rehabilitation & Health Care Center	Sandwich, IL
Shelbyville Rehabilitation & Health Care Center	Shelbyville, IL
Sheldon Health Care Center	Sheldon, IL
Sugar Creek Care Center	Watseka, IL
Sullivan Health Care Center	Sullivan, IL
Sunset Manor Nursing Home	Canton, IL
Timbercreek Rehabilitation & Health Care Center	Pekin, IL
Toulon Rehabilitation & Health Care Center	Toulon, IL
Tuscola Health Care Center	Tuscola, IL
Vandalia Rehabilitation & Health Care Center	Vandalia, IL
Watseka Rehabilitation & Health Care Center	Watseka, IL
Out-of-State:	
Meadow Lawn Nursing Center	Davenport, IA

Related Assisted Living	
Kewanee Courtyard Estates	Kewanee, IL
Kewanee Courtyard Village	Kewanee, IL
Monmouth Courtyard Estates	Monmouth, IL
Riverview Estates of Havana	Havana, IL
Simple Blessings	Casey, IL

Other Related Business Entities		
Petersen Health Care, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Health Care II, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Enterprises	Peoria, IL	Management/Bookkeeping
Petersen Health Systems	Peoria, IL	Management/Bookkeeping
Petersen Health Operations, L.L.C.	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	2.7	5.40	Salary	$ 31,655	L17,C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 31,655		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offic or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization: Petersen Health Care Companies
Street Address: 7218 N. Villa Lake
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	683,169	46	$ 82,166	$ 81,693	37,158	$ 4,469	1
2	2	Food	Patient Days	683,169	46	2,606		37,158	142	2
3	3	Housekeeping	Patient Days	683,169	46	1,857		37,158	101	3
4	4	Laundry	Patient Days	683,169	46	144		37,158	8	4
5	5	Utilities	Patient Days	683,169	46	12,513		37,158	681	5
6	6	Maintenance	Patient Days	683,169	46	107,775	81,080	37,158	5,862	6
7	7	Mgmt. Allocation of Benefits	Patient Days	683,169	46	23,459		37,158	1,276	7
8	10	Nursing and Medical Records	Patient Days	683,169	46	135,903	130,651	37,158	7,392	8
9	10A	Therapy	Patient Days	683,169	46	88		37,158	5	9
10	15	Mgmt. Allocation of Benefits	Patient Days	683,169	46	18,830		37,158	1,024	10
11	17	Administrative	Patient Days	683,169	46	582,000	582,000	37,158	31,655	11
12	19	Professional Services	Patient Days	683,169	46	168,984		37,158	9,191	12
13	20	Dues, Fees, Subs & Promos	Patient Days	683,169	46	76,921		37,158	4,184	13
14	21	Clerical & General Office	Patient Days	683,169	46	750,958	577,218	37,158	40,845	14
15	23	Inservice Training & Education	Patient Days	683,169	46	12,208		37,158	664	15
16	24	Travel & Seminar	Patient Days	683,169	46	16,731		37,158	910	16
17	25	Other Admin. Staff Transport	Patient Days	683,169	46	60,875		37,158	3,311	17
18	26	Insurance-Prop.Liab.Malp.	Patient Days	683,169	46	22,218		37,158	1,208	18
19	27	Mgmt. Allocation of Benefits	Patient Days	683,169	46	167,067		37,158	9,087	19
20	30	Depreciation	Patient Days	683,169	46	106,965		37,158	5,818	20
21	32	Interest	Patient Days	683,169	46	143,934		37,158	7,829	21
22	34	Rent - Facility & Grounds	Patient Days	683,169	46	13,500		37,158	734	22
23	35	Rent - Equipment & Vehicles	Patient Days	683,169	46	3,305		37,158	180	23
24										24
25	TOTALS					$ 2,511,007	$ 1,452,642		$ 136,576	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LaSalle Bank		X	Mortgage	$3,406.00	08/31/02	$ 3,145,161	$ 2,997,618	08/31/07	varies	$ 193,314	1
2	Chrysler Financial		X	Vehicle	$529.00	04/30/02	19,039		04/30/05	0.0694	112	2
3	Bank of Farmington		X	Vehicle	$1,152.00	09/20/01	55,280		01/02/2006	0.0725	540	3
4												4
5												5
	Working Capital											
6	LaSalle Bank		X	Working Capital	Interest Only	8/31/03	275,050		08/31/05	varies	10,667	6
7												7
8												8
9	TOTAL Facility Related				$5,087.00		$ 3,494,530	$ 2,997,618			$ 204,633	9
	B. Non-Facility Related*											
10								Home Office Allocation			7,829	10
11								Offset Interest Income			(41)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 7,788	14
15	TOTALS (line 9+line14)						$ 3,494,530	$ 2,997,618			$ 212,421	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7 (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report

1. Real Estate Tax accrual used on 2004 report.		$ 35,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2004	$ 34,591	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,009)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 37,009	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru		$ 36,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	12,660	8
2001	12,461	9
2002	31,194	10
2003	32,956	11
2004	34,591	12

Accrual based on prior year tax bill.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sunset Rehabilitation & Health Care COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0046094

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE 309-691-8113 FAX #: 309-691-8622

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-08-27-4338-017	Jones 2nd Add 67,68 E 1/2 69, E1/2	$ 34,591.00	$ 34,591.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 34,591.00	$ 34,591.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,554 B. General Construction Type: Exterior Brick Frame Steel Number of Stories Two

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization [X] (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortize [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2002	$ 95,000	1
2					2
3	TOTALS			$ 95,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	105		2002	1972	$ 2,315,000	$ 59,359	30	$ 77,167	$ 17,808	$ 270,084	4
5				2001	413,768	10,548	20	20,688	10,140	93,096	5
6	2			2003	148,271	3,780	20	7,414	3,634	18,535	6
7	8			2005	355,587	5,212	39	4,559	(653)	4,559	7
8	Allocated from Home Office			2005	37,028			694	694	694	8
	Improvement Type**										
9	Petersen Properties Building Partnership			1990	6,417		15	318	318	6,417	9
10	Petersen Properties Building Partnership			1991	10,127		15	675	675	9,844	10
11	Petersen Properties Building Partnership			1993	4,719		15	315	315	3,806	11
12	Petersen Properties Building Partnership			1994	1,780		15	119	119	1,388	12
13	Petersen Properties Building Partnership			1995	13,199		20	660	660	7,086	13
14											14
15	Field Audit			1990	1,102		15	38	38	1,102	15
16	Drapes			1995	8,206		20	410	410	4,237	16
17	Remodeling			1996	14,630	375	20	732	357	6,712	17
18	Awning			1996	1,105		20	55	55	500	18
19	Landscaping			1996	4,036	240	20	202	(38)	1,953	19
20	Back Taxes on Land			1996	531	52	20	27	(25)	209	20
21	Tiling			1997	500	34	20	25	(9)	200	21
22	Doors			1997	5,250	135	20	263	128	2,367	22
23	Tiling			1997	8,228	211	20	411	200	3,665	23
24	Gutters			1997	2,759	71	20	138	67	1,208	24
25	Landscaping			1997	1,886	113	20	94	(19)	823	25
26	Door Closer			1997	1,688	43	20	84	41	700	26
27	Concrete Slab			1997	1,440	37	20	72	35	624	27
28	Painting			1997	1,207	31	20	60	29	525	28
29	Furnace			1997	2,389	61	20	119	58	972	29
30	Awning			1997	4,077		20	204	204	1,734	30
31	Telephone System			1997	1,189		20	59	59	487	31
32	Roof/Windows			1998	36,145	927	20	1,807	880	13,553	32
33	Drapery			1998	1,402	36	20	70	34	525	33
34	Expansion Design			1998	3,639		20	182	182	1,365	34
35	Flooring/Cove Base			1998	619	16	20	31	15	233	35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Awnings	1999	$ 353	$ 32	20	$ 18	$ (14)	$ 117	37
38	Roof (Balance)	1999	1,000	26	20	50	24	325	38
39	Drapes	2000	1,966	50	20	98	48	539	39
40	Remove Trees	2000	1,072	27	20	54	27	297	40
41	Expansion	2000	1,945	50	20	97	47	538	41
42	Wood	2000	1,072	27	20	54	27	297	42
43	Land Work	2000	2,510	64	20	126	62	693	43
44	Flooring	2000	1,168	30	20	58	28	319	44
45	Shades	2001	1,788	46	20	89	43	401	45
46	Painting	2001	2,228	57	20	111	54	500	46
47	Carpet	2001	4,841	124	20	242	118	1,089	47
48	Carpet	2001	8,000	205	20	400	195	1,800	48
49	Painting	2001	345	9	20	17	8	77	49
50	Fire System	2001	42,286	1,084	20	2,114	1,030	9,513	50
51	Carpet	2001	2,155	55	20	108	53	486	51
52	Kitchen Remodeling	2001	43,315	581	20	2,166	1,585	9,747	52
53	Expansion	2002	7,352	64	20	368	304	1,290	53
54	Wall	2002	6,000	175	20	300	125	1,050	54
55	New Addition	2004	3,021	154	20	151	(3)	228	55
56	Stairway, sunroom, new additior	2004	218,275	5,597	20	10,914	5,317	16,371	56
57	Engineering Fees	2005	2,047		20	51	51	51	57
58	IDPH Planning Fee	2005	2,976		20	74	74	74	58
59	Architect Fees	2005	1,904		20	48	48	48	59
60									60
61									61
62									62
63	2005 - Home Office Allocation - Land Improvements	2005	2,140			66	66	66	63
64	2005 - Home Office Allocation - Building Improvements	2005	61			3	3	3	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,767,744	$ 89,738		$ 135,469	$ 45,731	$ 505,122	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numbe Sunset Rehabilitation & Health Car # 0046094 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 342,658	$ 26,444	$ 34,266	$ 7,822	10	$ 208,882	71
72	Current Year Purchases	22,315	3,189	1,116	(2,073)	10	1,116	72
73	Fully Depreciated Assets	165,723					165,723	73
74	Allocation from Home Office			5,055	5,055			74
75	TOTALS	$ 530,696	$ 29,633	$ 40,437	$ 10,804		$ 375,721	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1990 Dodge Intrepid	1994	$ 32,448	$ 1,675	$	$ (1,675)	4	$ 32,448	76
77	Facility	1997 Ford E350 Van	1997	41,836				4	41,836	77
78	Facility	2001 Dodge Caravan	2001	47,863	3,860	5,982	2,122	4	47,863	78
79	Facility	2001 Chevy	2002	17,143	1,775	4,286	2,511	4	13,241	79
80	TOTALS			$ 139,290	$ 7,310	$ 10,268	$ 2,958		$ 135,388	80

E. Summary of Care-Related Asset

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,532,730	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 126,681	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 186,174	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 59,493	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,016,231	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progres

	Description	Cost	
92		$	92
93			93
94	N/A		94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column (

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Home Office Allocation				734			6
7	TOTAL				$ 734 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: $ 10,028 Description: See attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Sunset Rehabilitation & Health Care
Provider # 0046094
12/31/2005 **Schedule 14A**

XII. Rental Costs
Line 16 - Rental Amount for Movable Equipment

Dish machine	1,996
Humidifier, bipap machine, heater & concentrator	7,329
Portable oxygen tank & oxygen concentrator	428
Specialty air mattress	95
Allocated from Home Office	180
	10,028

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits
(c) For in-house training programs only. Do not include fringe benefits
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A, 1&3	1780 hrs	$ 49,971	55	$ 3,439	$	1,835	$ 53,410	1
2	Licensed Speech and Language Development Therapist	10A, 1&3	150 hrs	5,127	175	11,282		325	16,409	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A 2&3	hrs		400	25,797	130	400	25,927	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				5,259		5,259	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen	39,2					3,286		3,286	13
14	TOTAL			$ 55,098	630	$ 40,518	$ 8,675	2,560	$ 104,291	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be lis on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,050	$ 2,050	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	489,580	489,580	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,464	6,464	6
7	Other Prepaid Expenses	14,001	14,001	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Assessments	10,779	10,779	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 522,874	$ 522,874	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	174,053	95,000	13
14	Buildings, at Historical Cost	3,658,588	3,767,744	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	688,130	669,986	16
17	Accumulated Depreciation (book methods)	(908,735)	(1,016,231)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Unimproved Land		76,115	22
23	Other(specify): Goodwill	1,790,000	1,790,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,402,036	$ 5,382,614	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,924,910	$ 5,905,488	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 371,504	$ 371,504	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	124,489	124,489	30
31	Accrued Taxes Payable (excluding real estate taxes)	31,175	31,175	31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,009	37,009	32
33	Accrued Interest Payable	10,468	10,468	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Accrued Expenses	18,136	18,136	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 592,781	$ 592,781	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,997,618	2,997,618	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,997,618	$ 2,997,618	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,590,399	$ 3,590,399	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,334,511	$ 2,315,089	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,924,910	$ 5,905,488	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,780,742	1
2	Restatements (describe):		2
3	**Rounding difference**	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,780,743	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	553,768	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 553,768	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,334,511	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Car	$ 3,572,094	1
2	Discounts and Allowances for all Level	91,376	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,663,470	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	233,299	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 233,299	8
	C. Other Operating Revenue		
9	Payments for Educatior		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	27,131	14
15	Telephone, Television and Radic	3,163	15
16	Rental of Facility Space		16
17	Sale of Drugs	120,644	17
18	Sale of Supplies to Non-Patient		18
19	Laboratory	6,049	19
20	Radiology and X-Ray		20
21	Other Medical Services	2,799	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 159,786	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income**	41	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 41	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	2,062	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,062	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,058,658	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	756,562	31
32	Health Care	1,715,284	32
33	General Administratior	521,278	33
	B. Capital Expense		
34	Ownership	377,162	34
	C. Ancillary Expense		
35	Special Cost Centers	76,021	35
36	Provider Participation Fee	58,583	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,504,890	40
41	**Income before Income Taxes (line 30 minus line 40)****	553,768	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 553,768	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity is a cash basis taxpayer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,763	1,763	$ 36,437	$ 20.67	1
2	Assistant Director of Nursing	2,080	2,080	45,362	21.81	2
3	Registered Nurses	7,815	8,572	199,517	23.28	3
4	Licensed Practical Nurses	21,062	21,795	418,842	19.22	4
5	CNAs & Orderlies	74,455	77,050	713,327	9.26	5
6	CNA Trainees					6
7	Licensed Therapist	2,776	2,776	55,098	19.85	7
8	Rehab/Therapy Aides	122	122	1,474	12.08	8
9	Activity Director	1,517	1,517	16,991	11.20	9
10	Activity Assistants	1,864	1,864	17,087	9.17	10
11	Social Service Workers	2,080	2,080	24,410	11.74	11
12	Dietician					12
13	Food Service Supervisor	3,176	3,296	21,985	6.67	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,466	16,698	128,479	7.69	15
16	Dishwashers					16
17	Maintenance Worker	2,080	2,080	22,920	11.02	17
18	Housekeepers	16,977	18,104	162,724	8.99	18
19	Laundry	6,540	7,127	50,382	7.07	19
20	Administrator	2,080	2,080	52,159	25.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,500	1,500	10,870	7.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Care Plan Coordir	2,080	2,080	38,863	18.68	32
33	Other(specify) See Schedule 20A	2,989	3,101	28,168	9.08	33
34	TOTAL (lines 1 - 33)	168,422	175,685	$ 2,045,095 *	$ 11.64	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	23 visits	7,800	9(3)	36
37	Medical Records Consultant	1 visit	73	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	3 visits	75	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultan				41
42	Respiratory Therapy Consultan				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Rehab Consultant	70 hrs	2,155	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 10,103		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Sunset Rehabilitation & Health Care
Provider # 0046094
12/31/2005

Line 33. Other - Staffing and Salary Costs (line 33 - Other)

Description	Hours Worked	Hours Pd & Accrued	Wages	Ave. Hrly Wages
Marketing personnel	1,040	1,040	10,937	10.52
Transportation	1,949	2,061	17,231	8.36
	2,989	3,101	28,168	9.08

Facility Name & ID Number: Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Margaret Farris	Administrator	0	$ 52,159
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.			$ 52,159

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Bush, Snyder & Associates	Legal	$ 365
Ginoli & Co.	Accounting	894
Altschuler, Melvoin & Glasser LLP	Accounting	5,600
American Express TBS	Accounting	2,055
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 8,914

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,034
Unemployment Compensation Insurance	44,104
FICA Taxes	154,003
Employee Health Insurance	83,379
Employee Meals	3,263
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	484
Employee Relations	4,991
TOTAL (agree to Schedule V, line 22, col.8)	$ 358,258

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 420
Advertising: Employee Recruitment	921
Health Care Worker Background Check	
(Indicate # of checks performed 22)	270
Licenses & Permits	302
Dues & Subscriptions	151
Home office allocation	4,184
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,248

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	204
Seminar Expense	500
Home office allocation	910
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,614

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Sunset Rehabilitation & Health Care
Provider # 0046094
12/31/2005 **Schedule 21A**

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)		8,914
Allocated from Home Office		
Legal	174	
Other	9,017	9,191
Total (agree to Schedule V, line 19, column 8)		18,105

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6						N/A							
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sunset Rehabilitation & Health Care # 0046094 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost repor **No**
If YES, give association name and amount **N/A**

(3) Did the nursing home make political contributions or payments to a politic action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at th end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases **Yes**
What was the average life used for new equipment added during this perioc **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expens and the location of this expense on Sch. V. $ **14,540** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedur consistent with prior reports? **Yes** If NO, attach a complete explanation

(8) Are you presently operating under a sale and leaseback arrangemen **No**
If YES, give effective date of lease **N/A**

(9) Are you presently operating under a sublease agreemen ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took ove
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmer during this cost report period. $ **58,583**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? **No** If YES, attach an explanation of the allocation

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed t the Department, in addition to the daily rate, been properly classifie in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services f the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attac a schedule which explains how all related costs were allocated to these function

(15) Indicate the cost of employee meals that has been reclassified to employee benefi on Schedule V. $ **3,263** Has any meal income been offset agains related costs? **Yes** Indicate the amount $ **27,131**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel **No**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation fc residents? **No** If YES, please indicate the amount of income earned from such program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients **49%**
d. Have vehicle usage logs been maintained **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all oth times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjust out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm **Yes**
Firm Name: **Ginoli & Co.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this cop been attached? **No** If no, please explain **Audit in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted o out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of servic performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fee

RECONCILIATION REPORT **12:11 PM** **5/16/2006**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	93,541	equal to	93,541	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	212,421	equal to	212,421	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	36,000	equal to	36,000	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	186,174	equal to	186,174	0	FAILED	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	734	equal to	734	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	10,028	equal to	10,028	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	55,098	equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	95,746	equal to	95,746	0	O.K.	Pg16 Z12+Z14.	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	8,675	equal to	8,675	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	756,562	equal to	756,562	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,715,284	equal to	1,715,284	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	521,278	equal to	521,278	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	377,162	equal to	377,162	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	76,021	equal to	76,021	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	58,583	equal to	58,583	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,453,822	equal to	1,453,822	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	55,098	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	34,078	equal to	34,078	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	24,410	equal to	24,410	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	150,464	equal to	150,464	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	22,920	equal to	22,920	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	162,724	equal to	162,724	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	50,382	equal to	50,382	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	52,159	equal to	52,159	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	10,870	equal to	10,870	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	2,045,095	equal to	2,045,095	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	7,800	< or = to	7,800	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	148	< or = to	2,303	-2,155	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to		0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	52,159	equal to	52,159	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	8,914	equal to	8,914	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	358,258	equal to	358,258	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	6,248	equal to	6,248	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	1,614	equal to	1,614	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	58,583	equal to	58,583	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	3,263	< or = to	3,263	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	3,263	equal to	3,263	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	2,608	equal to	2,608	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	136,576	equal to	136,576	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	2,997,618	equal to	2,997,618	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	37,009	equal to	37,009	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	95,000	equal to	95,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	3,767,744	equal to	3,767,744	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	669,986	equal to	669,986	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,016,231	equal to	1,016,231	0	FAILED	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	2,334,511	equal to	2,334,511	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	553,768	equal to	553,768	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	5,924,910	equal to	5,924,910	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Sunset Rehabilitation & Health Care
IDHFS Comparative Data - Per Resident Day Cost
Year Ending 12/31/2005

Enter your HSA # in next column =====> 2
Census (Pulls from Page 2) 37,158

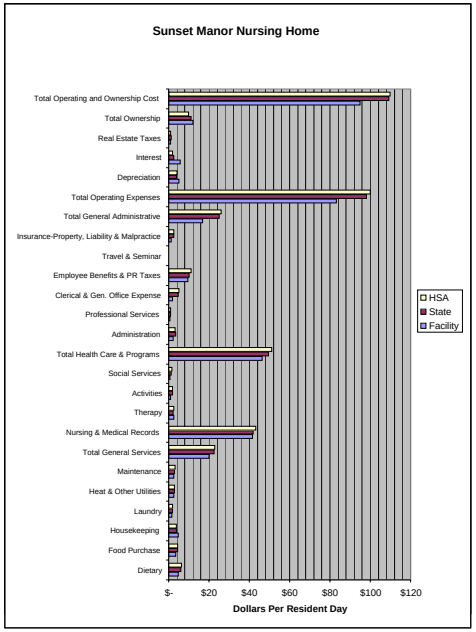
Cost Report Line	Description	Your Facility	Average Median Cost Per Day (2003) State	HSA
1	Dietary	4.92	6.01	6.48
2	Food Purchase	3.63	4.31	4.40
3	Housekeeping	4.79	3.70	3.68
4	Laundry	1.69	1.85	1.90
5	Heat & Other Utilities	2.43	2.95	2.93
6	Maintenance	2.39	3.01	3.03
8	Total General Services	19.88	22.58	22.99
10	Nursing & Medical Records	41.48	41.83	43.12
10A	Therapy	2.58	2.10	2.69
11	Activities	0.94	1.91	1.92
12	Social Services	0.68	1.42	1.64
16	Total Health Care & Programs	46.39	49.48	51.22
17	Administration	2.26	3.36	3.15
19	Professional Services	0.49	0.99	0.85
21	Clerical & Gen. Office Expense	1.94	4.79	4.97
22	Employee Benefits & PR Taxes	9.64	10.09	11.01
24	Travel & Seminar	0.04	0.08	0.13
26	Insurance-Property, Liability & Malpractice	1.34	2.58	2.55
28	Total General Administrative	16.78	24.94	26.11
29	Total Operating Expenses	83.05	98.06	100.03
30	Depreciation	5.01	3.70	4.08
32	Interest	5.72	2.54	1.96
33	Real Estate Taxes	0.97	1.38	1.08
37	Total Ownership	11.99	11.11	9.80
	Total Operating and Ownership Cost	95.03	109.17	109.83

Notes:
Your Facility data is from page 3, column 8 of your 2005 Medicaid cost report, divided by your annual census.

The Average Median Cost Per Day for the **State** and your **HSA** is taken from 2003 data available from the Illinois Department of Healthcare and Family Services and corresponds with the respective cost report data after final adjustments.

IDHFS LTC Profiles
LTC Median Per Diem Cost by HSA - 2003 Cost Reports
2003 (Run June 1, 2004) **UN-INFLATED**

Cost Report Line	Description	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11	10th %	90th %
1	Dietary	6.01	7.02	6.48	5.50	6.48	5.48	6.06	6.06	6.06	5.60	7.02	5.70	4.13	9.81
2	Food Purchase	4.31	4.47	4.40	4.27	4.40	3.99	4.31	4.31	4.31	4.28	4.47	4.11	3.36	6.04
3	Housekeeping	3.70	3.59	3.68	2.91	3.68	3.40	4.05	4.05	4.05	3.97	3.59	3.61	2.48	5.80
4	Laundry	1.85	2.23	1.90	1.79	1.90	2.10	1.59	1.59	1.59	1.69	2.23	2.13	0.91	3.14
5	Heat & Other Utilities	2.95	3.17	2.93	2.94	2.93	2.71	2.93	2.93	2.93	2.91	3.17	2.95	2.05	4.25
6	Maintenance	3.01	3.26	3.03	2.99	3.03	2.55	3.21	3.21	3.21	3.05	3.26	2.82	1.92	5.12
8	**TOTAL GENERAL SERVICES**	**22.58**	**24.49**	**22.99**	**21.14**	**22.99**	**21.47**	**22.65**	**22.65**	**22.65**	**22.45**	**24.49**	**21.73**	**17.57**	**31.51**
10	Nursing & Medical Records	41.83	42.52	43.12	38.37	43.12	33.78	45.12	45.12	45.12	47.22	42.52	42.15	27.25	64.47
10A	Therapy	2.10	1.86	2.69	3.34	2.69	3.47	1.45	1.45	1.45	2.41	1.86	2.24	-	10.55
11	Activities	1.91	2.18	1.92	1.61	1.92	1.48	2.16	2.16	2.16	2.05	2.18	1.54	1.06	3.45
12	Social Services	1.42	1.45	1.64	1.05	1.64	1.09	1.60	1.60	1.60	1.12	1.45	1.27	0.58	3.00
16	**TOTAL HEALTH CARE & PROGRAMS**	**49.48**	**50.39**	**51.22**	**46.39**	**51.22**	**41.58**	**52.34**	**52.34**	**52.34**	**54.96**	**50.39**	**49.49**	**32.10**	**77.23**
17	Administration	3.36	3.33	3.15	3.15	3.15	3.60	3.46	3.46	3.46	3.04	3.33	3.17	1.71	7.21
19	Professional Services	0.99	1.09	0.85	0.83	0.85	0.76	1.12	1.12	1.12	1.13	1.09	0.77	0.07	3.44
21	Clerical & Gen. Office Expense	4.79	4.32	4.97	3.98	4.97	3.46	5.56	5.56	5.56	5.04	4.32	4.25	2.49	10.78
22	Employee Benefits & PR Taxes	10.09	10.42	11.01	8.88	11.01	7.67	10.51	10.51	10.51	11.38	10.42	9.08	6.33	19.34
24	Travel & Seminar	0.08	0.10	0.13	0.10	0.13	0.13	0.06	0.06	0.06	0.05	0.10	0.07	-	0.43
26	Insurance-Property, liability & Malpractice	2.58	2.47	2.55	2.35	2.55	2.22	2.85	2.85	2.85	2.19	2.47	2.61	0.88	4.32
28	**TOTAL GENERAL ADMINISTRATIVE**	**24.94**	**25.31**	**26.11**	**23.02**	**26.11**	**21.37**	**25.81**	**25.81**	**25.81**	**26.59**	**25.31**	**22.93**	**16.95**	**39.14**
29	**TOTAL OPERATING EXPENSES**	**98.06**	**100.77**	**100.03**	**92.47**	**100.03**	**88.05**	**100.96**	**100.96**	**100.96**	**103.01**	**100.77**	**94.71**	**69.40**	**142.56**
30	Depreciation	3.70	3.82	4.08	3.29	4.08	2.54	4.11	4.11	4.11	3.54	3.82	3.38	1.01	8.43
32	Interest	2.54	2.81	1.96	2.09	1.96	1.41	4.05	4.05	4.05	2.63	2.81	1.50	-	11.53
33	Real Estate Taxes	1.38	0.92	1.08	0.82	1.08	0.80	3.20	3.20	3.20	1.36	0.92	1.11	-	4.85
37	**TOTAL OWNERSHIP**	**11.11**	**9.73**	**9.80**	**8.00**	**9.80**	**7.04**	**14.54**	**14.54**	**14.54**	**11.02**	**9.73**	**8.39**	**3.76**	**23.58**
	TOTAL OPERATING & OWNERSHIP CC	**109.17**	**110.50**	**109.83**	**100.47**	**109.83**	**95.09**	**115.50**	**115.50**	**115.50**	**114.03**	**110.50**	**103.10**	**73.16**	**166.14**



	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	150,464	27,799	0	178,263	0	178,263	4,469	182,732
2. Food Purchase	0	165,144	0	165,144	0	165,144	-30,252	134,892
3. Housekeeping	162,724	15,163	0	177,887	0	177,887	101	177,988
4. Laundry	50,382	12,433	0	62,815	0	62,815	8	62,823
5. Heat and Other Utilities	0	0	89,666	89,666	0	89,666	681	90,347
6. Maintenance	22,920	46,893	12,974	82,787	0	82,787	5,862	88,649
7. Other (specify)*	0	0	0	0	0	0	1,276	1,276
8. Total General Services	386,490	267,432	102,640	756,562	0	756,562	-17,855	738,707
9. Medical Director	0	0	7,800	7,800	0	7,800	0	7,800
10. Nursing & Medical Records	1,453,822	77,916	2,303	1,534,041	0	1,534,041	7,392	1,541,433
10a. Therapy	55,098	130	40,518	95,746	0	95,746	5	95,751
11. Activities	34,078	1,024	0	35,102	0	35,102	0	35,102
12. Social Services	24,410	954	0	25,364	0	25,364	0	25,364
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	17,231	0	0	17,231	0	17,231	0	17,231
15. Other (specify)*	0	0	0	0	0	0	1,024	1,024
16. Total Health Care & Programs	1,584,639	80,024	50,621	1,715,284	0	1,715,284	8,421	1,723,705
17. Administrative	52,159	0	0	52,159	0	52,159	31,655	83,814
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	8,914	8,914	0	8,914	9,191	18,105
20. Fees, Subscriptions & Promotion	0	0	2,064	2,064	0	2,064	4,184	6,248
21. Clerical & General Office	10,870	9,507	12,926	33,303	0	33,303	38,837	72,140
22. Employee Benefits & Payroll	0	0	354,995	354,995	0	354,995	3,263	358,258
23. Inservice Training & Education	0	0	2,786	2,786	0	2,786	664	3,450
24. Travel and Seminar	0	0	704	704	0	704	910	1,614
25. Other Admin. Staff Trans	0	0	17,642	17,642	0	17,642	3,257	20,899
26. Insurance-Prop.Liab.Malpractice	0	0	48,711	48,711	0	48,711	1,208	49,919
27. Other (specify)*	0	0	0	0	0	0	9,087	9,087
28. Total General Adminis	63,029	9,507	448,742	521,278	0	521,278	102,256	623,534
29. Total General Administrative	2,034,158	356,963	602,003	2,993,124	0	2,993,124	92,822	3,085,946
30. Depreciation	0	0	126,681	126,681	0	126,681	59,493	186,174
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	204,633	204,633	0	204,633	7,788	212,421
33. Real Estate	0	0	36,000	36,000	0	36,000	0	36,000
34. Rent - Facility & Grounds	0	0	0	0	0	0	734	734
35. Rent - Equipment & Vehicles	0	0	9,848	9,848	0	9,848	180	10,028
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	377,162	377,162	0	377,162	68,195	445,357
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	8,545	0	8,545	0	8,545	0	8,545
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	58,583	58,583	0	58,583	0	58,583
43. Other (specify):*	10,937	0	56,539	67,476	0	67,476	-67,476	0
44. Total Special Cost Ce	10,937	8,545	115,122	134,604	0	134,604	-67,476	67,128
45. Grand Total	2,045,095	365,508	1,094,287	3,504,890	0	3,504,890	93,541	3,598,431

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	2,050	2,050
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	489,580	489,580
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	6,464	6,464
7. Other Prepaid Expenses	14,001	14,001
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	10,779	10,779
10. Total current assets	522,874	522,874
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	174,053	95,000
14. Buildings, at Historical Cost	3,658,588	3,767,744
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	688,130	669,986
17. Accumulated Depreciation (book methods)	-908,735	-1,016,231
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	76,115
23. other (specify):	1,790,000	1,790,000
24. Total Long-Term Assets	5,402,036	5,382,614
25. Total Assets	5,924,910	5,905,488
CURRENT LIABILITIES		
26. Accounts Payable	371,504	371,504
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	124,489	124,489
31. Accrued Taxes Payable	31,175	31,175
32. Accrued Real Estate Taxes	37,009	37,009
33. Accrued Interest Payable	10,468	10,468
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	0	0
37. Other Current Liabilities (specify):	18,136	18,136
38. Total Current Liabilities	592,781	592,781
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	2,997,618	2,997,618
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	2,997,618	2,997,618
46.Total Liabilities	3,590,399	3,590,399
47.Total Equity	2,334,511	2,315,089
48.Total Liabilities and Equity	5,924,910	5,905,488

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,572,094
2. Discounts and Allowances for all Levels	91,376
Subtotal - Inpatient Care	3,663,470
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	233,299
7. Oxygen	0
Subtotal - Anciliary Revenue	233,299
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	27,131
15. Telephone, Television, and Radio	3,163
16. Rental of Facility Space	0
17. Sale of Drugs	120,644
18. Sale of Supplies to Non-Patients	0
19. Laboratory	6,049
20. Radiologyand X-Ray	0
21. Other Medical Services	2,799
22. Laundry	0
Subtotal - Other Operating Revenue	159,786
24. Contributions	0
25. Interest and Other Investments Income	41
Subtotal - Non-Operating Revenue	41
27. Other Revenue (specify):	2,062
28. Other Revenue (specify):	0
Subtotal - Other Revenue	2,062
30. Total Revenue	4,058,658
31. General Services	756,562
32. Health Care	1,715,284
33. General Administration	521,278
34. Ownership	377,162
35. Special Cost Centers	76,021
35. Provider Participation Fee	58,583
37. Other	0
40. Total Expenses	3,504,890
41. Income Before Income Taxes	553,768
42. Income Taxes	0
43. Net Income or Loss for the Year	553,768